DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175353	A. BUILDING ______ B. WING ______	C 06/12/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARMA HEALTH AND REHAB	**605 EAST MELVIN ST PO BOX 789 ARMA, KS 66712**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following citations represent the findings of complaint investigation #87235.	F 000		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This Requirement is not met as evidenced by: The facility reported a census of 29 residents with 3 sampled for elopement. Based on observation, interview, and record review, the facility failed to provide adequate supervision to prevent the elopement of 1 of the 3 sampled residents (#1) from the facility, without staff knowledge. Findings included: - The Physician Order Sheet, dated 5/7/15, documented the resident admitted on 3/18/15 with diagnoses including vascular dementia with depressed mood (progressive mental disorder characterized by failing memory, confusion), and behavioral problems. The Admission Minimum Data Set, dated 3/25/15, documented the resident Brief Interview for Mental Status score of 10, indicating moderately impaired cognition and required limited assist of one staff for ambulation on or off the unit with a cane or wheel chair used as a mobility device. The resident had no behaviors or wandering exhibited.	F 323		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F 323	Continued From page 1 The clinical admission observation report, dated 3/18/15 at 4:00 PM, documented the resident was not wandering, but had a history of elopement attempts or success and was identified as independent in ambulation with a cane. The report documented that on 3/18/15 a wanderguard was in place and on 4/17/15 it was discontinued. The nurses note, dated 5/16/15 at 1:45 PM, documented the resident was not found in the facility, after searching throughout each room thoroughly, another resident commented that they had seen this resident walking out the front door. After some searching, the resident was found a block away from the facility, walking toward the spouse's house. On 6/9/15 at 10:34 AM, Direct Care Staff C reported he/she was working when the resident eloped on 5/16/15. Staff C had just passed the resident walking down the hallway, gone into the shower room to clean it, came out a few minutes later and a visitor had asked where the resident was. The staff could not find the resident in the facility, so staff went outside the facility and did a sweep of the area. The resident was found by a staff member just down the road by the ball field. The resident ' s home was on the other side of the field, which is where the resident stated he/she was headed. The resident was wearing a blouse, pants, and either sandals or tennis shoes. It was after 1:00 PM, but before 2:00 PM, that afternoon when it happened. The resident was calm and seemed fine. Staff C had just seen and talked to the resident 5-10 minutes before he/she got out. Staff C stated the front doors were opened by a visitor, and the resident walked out. Staff C stated the resident may have been out of	F 323		

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F 323	Continued From page 2	F 323		

the facility a total of 15 minutes. Staff C did not consider the resident to be an elopement risk at that time.

On 6/9/15 at 3:21 PM, Administrative Nursing Staff B reported when the resident admitted to the facility, he/she was at risk for elopement because of exit seeking behaviors, and talking about wanting to be with family. The facility placed a wanderguard bracelet on the resident initially. Then, after a few weeks, the resident began to settle into a routine and calmed down. The resident was still confused, but was not talking about leaving anymore, was no longer going to the door looking for family and staff decided he/she was not at risk anymore because the signs and behaviors were gone. Also, staff was having difficulty with the resident leaving the bracelet on. The resident was able to remove the bracelet, no matter where it was placed. So, the staff decided to leave it off, because the resident gave no reason to feel like he/she was still at risk for elopement. Then, about a month later, the resident followed a visitor out the door. The resident had not been in the front area by the door, had not been talking about leaving, and had not been talking about wanting to see family that day, so the staff was taken by surprise completely. The resident was found quickly by the staff, across the street from the end of the facility heading toward the ball fields because his/her house and spouse were just on the other side of the fields. At that time, staff had not put a sign for visitors to watch for residents in the area of the door, so visitors did not know a resident could get out when they were coming or going.

The facility failed to provide adequate supervision for this resident who eloped from the facility without staff knowledge.